NHS Dorset Clinical Commissioning Group

NHS Dorset Clinical Commissioning Group

Procedure for the management of Serious Incidents



Supporting people in Dorset to lead healthier lives

PREFACE

This procedural document outlines the processes to be adopted to ensure the thorough investigation of Serious Incidents reported to, and by, NHS Dorset CCG.

All managers and staff (at all levels) are responsible for ensuring that they are viewing and working to the current version of this procedural document. If this document is printed in hard copy or saved to another location, it must be checked that the version number in use matches with that of the live version on the CCG intranet.

All CCG procedural documents are published on the staff intranet and communication is circulated to all staff when new policies or changes to existing procedural documents are released. Managers are encouraged to use team briefings to aid staff awareness of new and updated procedural documents.

All staff are responsible for implementing procedural documents as part of their normal responsibilities, and are responsible for ensuring they maintain an up to date awareness of procedural documents.

A	SUMMARY POINTS
•	Following the publication of the new Serious Incident Framework by NHS England (March 2015) it was necessary for the CCG to review all procedures in relation to the management of Serious Incidents.
•	Following this review, this procedure explains the processes involved in managing Serious Incidents within NHS funded care which affect one or more Dorset patients.
•	There are six different types of Serious Incident; these are detailed within the procedure including examples of the different types, and the different ways of managing these incidents.
•	The procedure for the management of Adverse Incidents is explained in a separate procedure.

B	ASSOCIATED DOCUMENTS
•	Duty of Candour and Being Open Policy, 2017
•	Customer Care and Complaints Policy, 2016
•	Health and Social Care Information Centre/Department of Health Checklist guidance for reporting, managing and investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation, 2015
•	Procedure of the development and management of procedural documents, 2017
•	Procedure for the management of adverse incidents, 2015
•	Risk Management Framework, 2017
•	Whistleblowing Policy, 2016
•	Safeguarding Adult and Children Policy, 2017
•	The NHS England Response to the Recommendations in the William Mead Root Cause Analysis, 2016

C	DOCUMENT DETAILS	
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E	VERSION CONTROL				
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18.08.2015	1	18.08.2017	New procedure to reflect the newly published Serious Incident Framework, NHS England, March 2015	18.08.2015	Directors Performance Meeting
21.11.2017	2	21.11.2019	Updates to reflect delegated authority and responsibility for Primary Care Serious Incidents	21.11.2017	Directors Performance Meeting
06.02.2018	3	21.11.2019	Updated hyperlinks to reflect publication of new Never Event policy and framework	n/a	n/a

F	SUPPORTING DOCUMENTS/EVIDENCE BASED REFERENCES	
Evidence	**Hyperlink (if available)**	**Date**
Being Open Framework and Guidance, NHS NPSA NRLS	http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=83726	2009
Being open: Communicating patient safety incidents with patients, their families and carers, National Patient Safety Agency National Reporting and Learning Service, November 2009, Appendix B	http://nrls.npsa.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=65172	2009
Care Act Duty of Candour regulations. NHS England: Social Care England: Public Health England.	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted	2014
Serious Incident Framework, NHS England	http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf	2015
Never Events Framework	https://improvement.nhs.uk/uploads/documents/Revised_Never_	2018

	Events_policy_and_framework_FINAL.pdf	
Never Event List 2018	https://improvement.nhs.uk/uploads/documents/Never_Events_list_2018_FINAL_v5.pdf	2018
Working together to safeguard children, MH Government	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf	2015
UK Cyber Security Strategy, 2011	https://www.gov.uk/government/publications/national-cyber-security-strategy-2016-to-2021	2016
Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, Home Office, December 2016	https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews	2016
Chief Coroner, Guidance No 16A Deprivation of Liberty Safeguards (DoLS) – from 3rd April 2017.	http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2017/03/GUIDANCE-No16A-DEPRIVATION-OF-LIBERTY-SAFEGUARDS-3rd-APRIL-2017-ONWARDS.pdf	2017

G	**DISTRIBUTION LIST**		
Internal CCG Intranet	**CCG Internet Website**	**Communications Bulletin**	**External stakeholders**
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PROCEDURE FOR THE MANAGEMENT OF SERIOUS INCIDENTS

1.0 RELEVANT TO

1.1 This procedure is relevant to all individuals interested in the procedure for the management of Serious Incidents by NHS Dorset Clinical Commissioning Group. This includes (but is not limited to) staff employed by the CCG, NHS England, providers of NHS funded healthcare for Dorset residents and members of the public.

1.2 Additionally, this procedure will be of interest to NHS England as the organisation with oversight and surveillance of serious incident management within NHS-funded care and the organisation that seeks assurance that CCGs have systems in place to appropriately manage serious incidents in the care they commission.

2.0 INTRODUCTION

2.1 NHS Dorset Clinical Commissioning Group (hereafter known as the CCG) is committed to the achievement of a high standard of health, safety and welfare for all patients, members of the public, employees and others engaged in or affected by the activities and services of the CCG.

2.2 In March 2015, following widespread consultation NHS England published two new patient safety documents; a revised Never Events Policy and Framework and a revised Serious Incident Framework, which both became active on 1st April 2015.

2.3 The revised Serious Incident Framework aimed to build on previous guidance, which introduced a systematic process for responding to serious incidents in NHS-funded care. It replaced the *National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010)* and NHS England's *Serious Incident Framework (March 2013)*.

2.4 Both documents required action to be taken by commissioners and providers to ensure local policies and procedures remain in-line with these national policy frameworks. The action of the CCG is reflected in this procedural document.

3.0 SCOPE

3.1 This procedural document explains the processes involved in managing Serious Incidents within NHS funded care (primary and secondary care) which affect one or more Dorset patients.

3.2 The definition of 'Serious Incident' is as per the NHS England Serious Incident Framework (March 2015) (see **Section 5.8** – Definitions)

3.3 This document does not include:

- the management of incidents which do not meet the 'Serious Incident' definition. These are known as 'Adverse Incidents'; the process which details how to manage adverse incidents is explained in a separate

procedure (Procedure for the management of Adverse Incidents; Reference ID 49);

3.4 The scope of this procedural document has been expanded (October 2017) to include the process for managing Serious Incidents declared in GP practices following the CCG receiving delegated authority from NHS England to manage this process in April 2016.

4.0 PURPOSE

4.1 This procedure is not meant to act as a duplication of the comprehensive NHS England Serious Incident Framework (March 2015) and Revised Never Events Policy and Framework (January 2018). This procedure explains the processes utilised by the CCG to ensure these frameworks are followed.

4.2 The objective of this document and its effective implementation is to:

- Establish a procedural document for managing Serious Incidents;
- Clearly document the six types of Serious Incident (see **Section 5.2**) managed by the CCG, and the differences in managing each type;
- Ensure that all Serious Incidents which occur within NHS-funded health care in Dorset are reported, investigated and closed as per the requirements of the NHS England Serious Incident Framework;
- Ensure Providers can understand the declaration and closure process that the CCG follows when a Serious Incident is declared;
- Document how the CCG will use lessons learnt to inform systematic learning and improvement;
- Ensure that Information Governance and Cyber-related Serious Incidents are managed appropriately in accordance with NHS Digital/Department of Health guidance;
- Ensure the CCG internal processes for the management of Serious Incidents are clearly documented for CCG staff and Providers of NHS-funded care to follow.

5.0 DEFINITIONS

5.1 This procedural document is a procedure as it provides a clear explanation of what must be done once a Serious Incident is identified by and/or reported to the Patient Safety and Risk team within Dorset CCG.

Types of Serious Incident

5.2 There are six different types of Serious Incident; these are detailed below, with further information, including examples, in **Appendix A**.

No	Type Title	Closure Mechanism
1	Provider Declared (Single Agency)	Serious Incident Review Group
2	Provider Declared (Multi Agency)	Serious Incident Review Group
3	Provider Declared Never Event (Single Agency)	Serious Incident Review Panel
4	CCG Declared (Internal CCG)	Serious Incident Review Panel
5	CCG Declared (Single Agency)	Serious Incident Review Group
6	CCG Declared (Multi Agency)	Serious Incident Review Panel

5.3 The six types will be frequently referred to (Type 1, Type 2 etc.) throughout this document as there are different approaches for managing each type of Serious Incident.

5.4 Further information about the roles of the CCG Serious Incident Review Group and CCG Serious Incident Review Panel to facilitate closure can be found in **Section 6** and **Appendix B**.

Terms and definitions for grading patient safety incidents

5.5 On a Pan-Dorset basis, patient safety incidents are graded as per the National Learning and Reporting System (NRLS) definitions:

Grade of incident	Definition
No harm	Incident prevented – any patient safety incidents that had the potential to cause harm but was prevented, and no harm was caused to patients receiving NHS-funded care. Incident not prevents – any patients' safety incident that occurred but no harm was caused to the patients receiving NHS-funded care.
Low harm	Any patient safety incident that required extra observation or minor treatment and caused minimal harm to one or more patients receiving NHS-funded care. *Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned; nor does it include a return to surgery or readmission.*
Moderate harm	Any patient safety incident that resulted in a moderate increase in treatment and that caused significant but not permanent harm to one or more patients receiving NHS-funded care. *Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or, as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.*

Severe harm	Any patient safety incident that appears to have resulted in permanent harm to one or more patients receiving NHS-funded care. *Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.*
Death	Any patient safety incident that directly resulted in the death of one or more patients receiving NHS-funded care. *The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.*

Strategic Executive Information System (STEIS)

5.6 The web-based serious incident management system used by NHS England is STEIS (the Strategic Executive Information System).

5.7 Not all commissioned Providers of NHS funded care have access to STEIS to notify the CCG that a Serious Incident (or suspected Serious Incident) has occurred. The Dorset organisations with access to STEIS are:

- Dorset County Hospital NHS Foundation Trust (DCHFT)
- Dorset HealthCare University NHS Foundation Trust (DHUFT)
- The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH)
- Poole Hospital NHS Foundation Trust (PHFT)
- South Western Ambulance Service NHS Foundation Trust (SWASFT)

5.8 When a Serious Incident occurs in a Provider which does not have access to STEIS (e.g. nursing homes, care homes, hospices, GP practices) the CCG declares the Serious Incident on behalf of the Provider. Within this procedure, this is Type 5.

Definition of Serious Incident (as per NHS England Serious Incident Framework)

5.9 This section explains what a Serious Incident is, via extracts from the NHS England Serious Incident Framework.

5.10 Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

5.11 Serious Incidents include acts of omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services

5.12 There is no definitive list of events/incidents that constitute a Serious Incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list.

5.13 The definition below sets out circumstances in which a Serious Incident must be declared. Every incident must be considered on a case-by-case basis using the description below. Inevitably, there will be borderline cases that rely on the judgement of the people involved.

5.14 In the event of disagreement or a lack of clarity as to whether a Serious Incident has occurred or not, the Director of Nursing and Quality, as the Accountable Director, will work with the Provider Director of Nursing or GP Practice to reach an agreement regarding declaration of the incident on STEIS.

5.15 Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death of one or more people. This includes
        - suicide/self-inflicted death; and
        - homicide by a person in receipt of mental health care within the recent past
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
        - the death of the service user; or
        - serious harm
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse,

self-neglect, domestic abuse, human trafficking and modern day slavery where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or

- where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See **Section 5.15** for the national definition and further information)

- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;

    - Property damage;

    - Security breach/concern;

    - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;

    - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);

    - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or

    - Activation of Incident Response Plan (by provider, commissioner or relevant agency)

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

5.16 **Never Events** are a subset of Serious Incidents that meet all of the following criteria:

- They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers

- Each Never Event has the potential to cause serious harm or death. However serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event

- There is evidence that the category of Never Event has occurred in the past for example through reports to the National Reporting and Learning system, and a risk of recurrence remains

- Occurrence of the Never Event is easily recognised and clearly defined – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.

- For further information on Never Events, refer to the Revised Never Event Policy and Framework, NHS England, January 2018.

Reporting Information Governance Incidents

5.17 An Information Governance Serious Incident is any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and/or the Common Law of Confidentiality. This includes unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy. This definition applies irrespective of the media involved and includes both electronic and paper records relating to staff and service users.

5.18 All organisations processing health and adult social care personal data should use the Information Governance Toolkit Incident Reporting Tool to report Level 2 Information Governance Serious Incidents to the Department of Health, NHS England and the Information Commissioner's Office (ICO). This includes Level 2 cyber-related incidents.

5.19 A cyber-related incident is anything that could compromise information assets within cyber space. "Cyberspace is an interactive domain made up of digital networks that is used to store, modify and communicate information. It includes the internet, but also the other information systems that support our businesses, infrastructure and services", UK Cyber Security Strategy, 2011.

6.0 ROLES AND RESPONSIBILITIES

NHS Dorset CCG

6.1 As per the requirements of the NHS England Serious Incident Framework commissioners are accountable for quality assuring the robustness of their Providers' Serious Incident investigations and the development and implementation of effective actions, by the Provider, to prevent recurrence of similar incidents.

6.2 To ensure that this happens, the CCG Serious Incident Review Group and CCG Serious Incident Review Panel are responsible for ensuring a robust quality assurance process is in place for the closure of Serious Incidents on behalf of the CCG Governing Body.

Director of Nursing and Quality

6.3 The Director of Nursing and Quality is the designated lead within the CCG, and is responsible for:

- ensuring that appropriate structures are in place to manage all Serious Incidents which occur within NHS funded health care in Dorset;
- monitoring the effectiveness of this procedure;
- chairing the Serious Incident Review Panel (or appointing a suitable representative);
- in instances of dispute, agreeing with Provider colleagues whether an incident need to be declared as a Serious Incident or not;
- ensuring that responsibility for managing information incidents is assigned to the Head of Information Governance and Customer Care.

Head of Patient Safety and Risk

6.4 The Head of Patient Safety and Risk is responsible for:

- the overall management of this procedure;
- ensuring the processes and procedures within this document are correctly adhered to;
- agreeing when a Type 4, Type 5 or Type 6 Serious Incident is to be declared on STEIS;
- Organising scoping meetings to agree the Lead Provider and RASCI model following incidents involving a number of Providers.
- identifying the most appropriate person within the CCG to sit on a Domestic Homicide Review (DHR) panel and to identify the most appropriate person to work with the GP practice in compiling the Individual Management Report (IMR) for the DHR;
- identifying the most appropriate person within the CCG to sit on a Serious Case Review panel and to identify the most appropriate person to work with the GP practice in compiling the Individual Management Report (IMR);
- reviewing the content of an IMR, via a Serious Incident Review Group for final sign off, before it is submitted to the DHR panel. In some cases, additional support and scrutiny is sought if the case is significantly complex;

- dissemination of any recommendations from both the IMR and, where appropriate, the Overview Report and to seek assurance that any remedial action is completed.

Patient Safety and Risk Manager

6.5 The Patient Safety and Risk Manager is responsible for:

- the day to day management of this procedure;
- ensuring this procedure is reviewed within the required timeframe;
- overseeing the organisation and administration of the Serious Incident Review Group and Serious Incident Review Panel;
- ensuring the Terms of Reference for Serious Incident Review Group and Serious Incident Review Panel are reviewed annually;
- reviewing all Standard Operating Procedures referred to within this procedure prior to publication;
- ensuring that the Standard Operating Procedures referred to within this procedure are up to date and adhered to at all times;
- reporting trend/theme information to the CCG Quality Safety Information Group (QSIG) on a monthly basis;
- reporting theme/trend/incidence information to the Quality Group on a quarterly basis;
- ensuring that any learning identified from the Serious Incident review process is shared to a wider audience, as appropriate;
- Attending (in person or virtual) when other providers' Serious incident review panels;

Patient Safety and Risk Facilitator and Patient Safety and Risk Co-ordinator

6.6 The Patient Safety and Risk Facilitator and Patient Safety and Risk Co-ordinator are responsible for:

- acknowledging all Provider Serious Incidents on STEIS within 48 business hours of receipt;
- declaring Type 4, 5 and 6 Serious Incidents on STEIS once the CCG is in receipt of the required information, once authorised to do so by the Head of Patient Safety and Risk;

- notifying NHS England when a Serious Incident is declared by the CCG on behalf of a GP practice and sending NHS England a copy of the final RCA report and action plan when closed on STEIS;

- deleting Serious Incidents from STEIS when agreed by Serious Incident Review Group or Serious Incident Review Panel;

- writing and maintaining the Standard Operating Procedures referred to within this procedure;

- following the Standard Operating Procedures referred to within this procedure;

- supporting small Providers (e.g. care homes/nursing homes/GP practices) to undertake Type 5 investigations;

- producing theme/trend reports for internal and Provider use, as per an agreed schedule;

- managing the weekly Serious Incident Group agenda, ensuring all documents are available and the appropriate people are able to attend the meeting;

- inviting Providers to attend both Serious Incident Review Group and Serious Incident Review Panel meetings;

- ensuring that the meeting outcome database is up to date and the required communication takes place with the Providers after each meeting.

Head of Information Governance and Customer Care

6.7 The Head of Information Governance and Customer care is responsible for:

- overseeing all investigations into information and cyber related incidents;

- reporting of Serious Incidents using the Information Governance Toolkit Incident Reporting Tool to inform the Department of Health, NHS England and the Information Commissioners Office;

- ensuring that learning is identified from investigations and is embedded throughout the organisation.

Medicines Safety Officer

6.8 The Medicines Safety Officer is responsible for:

- ensuring that Serious Incidents that involve Controlled Drugs have been directly reported to the Area Team Controlled Drugs Accountable Officer (CDAO) at NHS England via the NHS England CD reporting tool at www.cdreporting.co.uk;

- reviewing all Serious Incidents RCAs involving medicines management and providing feedback to the Serious Incident Review Panel;

- attending the Serious Incident Review Panel when the Serious Incident being discussed is a Never Event involving medicines management.

7.0 PROCESS FOR MANAGING SERIOUS INCIDENTS

Declaring Serious Incidents

7.1 All Serious Incidents must be declared as soon as possible and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation.

7.2 Serious Incidents should be disclosed as soon as possible to the patient, their family (including victims' families where applicable) or carers.

7.3 For Type 1, 2 and 3 Serious Incidents, the CCG must be informed via STEIS (and verbally if required) of a Serious Incident within two working days of it being discovered. Other regulatory, statutory and advisory bodies, such CQC, the HealthCare Safety Investigation Branch (HSIB), Monitor or NHS Trust Development Authority, must also be informed as appropriate without delay.

7.4 For Type 4 Serious Incidents, the CCG must declare, via STEIS, a Serious Incident within two working days of it being discovered. Other regulatory, statutory and advisory bodies, such CQC, Monitor or NHS Trust Development Authority, must also be informed as appropriate without delay.

7.5 For Type 5 Serious Incidents, the CCG will declare, via STEIS a Serious Incident when the full details of the incident have been supplied by the Provider at which the Serious Incident occurred.

7.6 For Type 6 Serious Incidents, the CCG will declare, via STEIS, a Serious Incident when the full details of the incident are known and understood, and an agreement has been reached that it is most appropriate for the Serious Incident to be declared by the CCG and not one of the Providers involved. Through increased use of the RASCI model, developed at the initial scoping meeting, it is the intention of the Patient Safety and Risk team to only declare multi-agency Serious Incidents (Type 6) is rare circumstances; the preferred approach is to agree the Lead Provider organisation at the scoping meeting (who will declare the incident on STEIS), and the CCG act in a supporting role to that organisation. **Appendix D** provides an illustration of the RASCI model agreed to investigate a multi-agency incident.

Logging Serious Incidents within Ulysses

7.7 For Type 1, 2 and 3 Serious Incidents, upon receipt of the notification from STEIS, it is the responsibility of the Patient Safety and Risk team to log all Serious Incidents within the Ulysses software 'Safeguard Risk Management System'.

7.8 Standard Operating Procedures are in place within the Patient Safety and Risk team to ensure that this process is consistently applied. These are available on request (CCG staff only) from the Patient Safety and Risk team.

7.9 The process for acknowledging, receiving and logging a new Serious Incident to STEIS/Ulysses can be found in Standard Operating Procedure 5-PS&R-01.

7.10 For Type 4, 5 and 6 Serious Incidents, the process for logging a new Serious Incident to STEIS/Ulysses can be found in Standard Operating Procedure 5-PS&R-02.

7.11 Some Serious Incidents require either the involvement of a member of the Safeguarding team (Adult and/or Children's) or for a member of the team to be notified. The process for identifying the need for safeguarding involvement can be found in Standard Operating Procedure 5-PS&R-01.

72-hour review

7.12 The Serious Incident Framework states that "an initial review (characteristically termed a '72-hour review') should be undertaken and uploaded onto the STEIS system by the Provider. This should be completed within three working days of the incident being identified."

7.13 NHS Dorset CCG has taken a pragmatic view on this requirement, as for some Serious Incidents, a 72-hour review will not 'add value'. Agreement has been reached with the local Providers that a 72-hour review will be provided only when:

- The Serious Incident is a Never Event;
- Independent investigations are to be undertaken;
- At the specific request of the CCG, when additional information can be readily obtained and may significantly expand early knowledge of the incident and why it occurred to quickly prevent further incidents.

7.14 72-hour review reports will not routinely be requested for Serious Incidents subject to concise and comprehensive investigations.

Duty of Candour

7.15 The NHS Constitution was updated in 2013 to include the requirements for NHS organisations under 'Duty of Candour'.

7.16 Communicating honestly and compassionately with patients and their families when things go wrong is a vital component in dealing effectively with errors or mistakes in their care.

7.17 The requirement in relation to applying Duty of Candour following Serious Incidents is clearly documented in the NHS England Serious Incident Framework.

7.18 In addition to highlighting the need for findings to be shared with the patient/family, the NHS England Response to the Recommendations in the

William Mead Root Cause Analysis May 2016 (Action 14.3c) reiterates "*the need for families to be involved in every step of the process, to ensure their concerns have been heard and addressed in the learning*".

7.19 The RCA should make it clear that Duty of Candour has been undertaken. In circumstances when Duty of Candour has not been undertaken, this must be documented, clearly addressing the reasons why. It is not acceptable to list 'next of kin not known' – in these circumstances, the steps taken to obtain this information (e.g. contacting the patient's GP practice) must be documented. Likewise, if a patient and/or their family has not responded to numerous and varied attempts to make contact, this must also be documented.

7.20 For Type 1, 2, 3 and 5 Serious Incidents, it is the responsibility of the Serious Incident Review Group or Serious Incident Review Panel to gain assurance that Duty of Candour has been applied and appropriately documented in relation to the incident by the Provider who declared the Serious Incident.

7.21 For all Type 4 Serious Incidents it is the responsibility of the CCG to apply Duty of Candour.

7.22 For all Type 6 Serious Incidents it is the responsibility of the Head of Patient Safety and Risk to ascertain the most appropriate organisation to take the lead with regards to applying Duty of Candour. A decision is reached via a 'scoping meeting' to agree which organisation will lead on Duty of Candour. It is imperative that Duty of Candour conversations commence early in the investigation process to ensure that any questions raised by the patient and/or their family can be included in the Terms of Reference and answered as part of the investigation report. A RASCI should be agreed as part of this process (see **Sections 7.66 - 7.67** and **Appendix D**).

7.23 The CCG and all Providers should make it clear to patients and/or their families that the final version of the report is not shared until the RCA has been reviewed by the CCG and closed on STEIS. When reports are shared with the patient and/or their family prior to closure on STEIS by the CCG it must be made clear that the report is still a 'draft version' until closed, and that changes ranging from minor to significant may be made once review of the incident has taken place.

Terms of Reference

7.24 It is a requirement of the Serious Incident Framework that each Serious Incident investigation has a clearly determined Terms of Reference.

7.25 For Types 1, 2, 3 and 5 Serious Incidents, it is the responsibility of the Provider to determine the Terms of Reference of the investigation. It is deemed helpful if these Terms of Reference are included in the RCA submitted to the CCG.

7.26 The CCG can provide support to small Providers (Type 5) to determine the Terms of Reference, if required.

7.27 When a Type 4 Serious Incident is declared it is the responsibility of the designated Lead Investigator to set Terms of Reference for the investigation. This would be undertaken in conjunction with the Patient Safety and Risk

Manager to ensure consistency of Terms of Reference for CCG declared Serious Incidents.

7.28 When, due to the number of Providers involved in the Serious Incident (Type 6), the Terms of Reference must be agreed by all stakeholders/Providers at the initial scoping meeting detailed in **Section 7.6**. It is also at this meeting that the organisation who will lead the investigation will be established, and a RASCI agreed (see **Sections 7.66 -7.67**).

7.29 For all types of Serious Incident, the Lead Investigator is responsible for ensuring that the patient/family/carer of those affected have the opportunity to inform the Terms of Reference for the investigation.

Investigation timeframe

7.30 The Serious Incident Framework states that RCAs (concise and comprehensive investigations) must be completed within 60 working days of the incident being reported to the CCG.

7.31 The Patient Safety and Risk team maintain regular contact with the Risk Departments at each of the Providers requesting updates in relation to when investigations are past their due date.

7.32 The CCG expects Providers to meet the 60 working days' requirement however there may be occasions when this cannot be achieved. This timeframe can be particularly challenging for Type 3 and 6 investigations when additional meetings/panels need to be convened. In the circumstances when additional time is required, this should be discussed and agreed with the Patient Safety and Risk team.

Factual accuracy

7.33 In all Serious Incident reports, and in particular, complex investigations involving one or more Provider, it is essential that the final draft of the RCA is shared with all stakeholders/Providers for accuracy before the final version is agreed. This 'final checking' stage should also include input from specialist colleagues (for example. a Pharmacist may pick up that a report contains reference to a medicine's strength that does not exist).

CCG Serious Incident Review Group (Type 1 and 2 Serious Incidents)

7.34 The Serious Incident Review Group has been given the authority to close Type 1, Type 2 and Type 5 Serious Incidents only.

7.35 Upon receipt of the RCA the Patient Safety and Risk team updates the STEIS/Ulysses entry with the RCA findings.

7.36 The process for preparing a Serious Incident for Serious Incident Review Group can be found in Standard Operating Procedure 5-PS&R-03.

7.37 The membership of the Serious Incident Review Group comprises of:

- Head of Patient Safety and Risk, NHS Dorset CCG (Chair)

- Patient Safety and Risk Manager, NHS Dorset CCG (Deputy Chair)
- Patient Safety and Risk Facilitator, NHS Dorset CCG;
- Patient Safety and Risk Co-ordinator, NHS Dorset CCG;
- Head of Quality and Patient Safety, NHS West Hampshire CCG (for when Serious Incidents being reviewed involve West Hampshire residents);
- Patient Safety Manager, NHS England (Wessex) (three to four times per year, for assurances purposes).

7.38 In addition to the above members, other key staff will be invited to attend as required to meetings, for example, Safeguarding Leads, Medicines Management, Infection Control and Prevention team.

7.39 When the Serious Incident has occurred in a GP Practice, the RCA and action plan must be reviewed prior to the closure meeting by an independent GP for peer review and comment. This will be managed by the Patient Safety and Risk team.

7.40 The Deputy Director of Nursing and Quality or Heads within the Quality Directorate may attend any Serious Incident Review Group meetings on an ad hoc basis as they wish or are required.

7.41 The meeting may proceed with either the Head of Patient Safety and Risk or Patient Safety and Risk Manager but must be cancelled or rescheduled if neither can attend. Alternatively, arrangements could be made for the Head of Quality Improvement or Director/Deputy Director of Nursing and Quality to attend either in person or 'virtually' (having had the opportunity to comment on the report via the Serious Incident Review Panel Outcome Summary **(Appendix C)**).

7.42 The full Terms of Reference of the Serious Incident Review Group can be viewed in **Appendix B** and in 5-PS&R-03.

7.43 The process for documenting and following up on actions from the Serious Incident Review Group can be found in Standard Operating Procedure 5-PS&R-03

CCG Serious Incident Review Panel (Type 3, 4, 5 and 6 Serious Incidents)

7.44 A Serious Incident Review Panel has the authority to close Type 3, 4 and 6 Serious Incidents.

7.45 As 'Never Events' the CCG seeks the additional level of scrutiny of Type 3 Serious Incidents from convening a wider panel of CCG representatives.

7.46 Additionally, a higher level of scrutiny is required for Type 4 and 6 Serious Incidents as the CCG is responsible, under the terms of the new Serious Incident Framework, for closing Serious Incidents which the CCG declared.

7.47 Upon receipt of the RCA the Patient Safety and Risk team updates the STEIS/Ulysses entry with the RCA findings.

7.48 The process for preparing a Serious Incident for Serious Incident Review Panel can be found in Standard Operating Procedure 5-PS&R-04.

7.49 The membership of the Serious Incident Review Panel comprises of:

- Director of Nursing and Quality, or Deputy Director, NHS Dorset CCG (Chair);
- Governing Body, Nurse Member, NHS Dorset CCG;
- An independent GP member, NHS Dorset CCG (no conflict of interest with any case presented);
- Head of Patient Safety and Risk, NHS Dorset CCG;
- Patient Safety and Risk Manager, NHS Dorset CCG;
- Head of Quality and Patient Safety, NHS West Hampshire CCG (for when Serious Incidents being reviewed involve West Hampshire residents);
- Patient Safety Manager, NHS England (Wessex);
- NHS trust representative, (attends only the part of the meeting to present their case).

7.50 In addition to the above members, other key staff will be invited to attend as required to meetings, for example, Safeguarding Leads, Medicines Management, Infection Control and Prevention team.

7.51 The full Terms of Reference of the Serious Incident Review Panel can be viewed in **Appendix B** and in 5-PS&R-04.

7.52 The process for documenting and following up on actions from the Serious Incident Review Panel can be found in Standard Operating Procedure 5-PS&R-04.

Closing Serious Incidents on STEIS

7.53 Serious Incidents will only be closed on STEIS following receipt of a robust investigation report that has been generated following a full root cause analysis with a time framed action plan that will be monitored by the Lead Commissioner.

7.54 A Lead Commissioner is usually the commissioner with the greatest contract value, as per the Serious Incident Framework recommendation.

7.55 Serious Incidents can only be closed following agreement from the Serious Incident Review Group or Serious Incident Review Panel. The closure checklist in **Appendix C** is used to facilitate closure.

7.56 If it is agreed during the Group or Panel meeting that the Serious Incident can be closed, the Serious Incident can be closed on STEIS by a member of the Patient Safety and Risk team and the Provider(s) notified of the closure.

7.57 If it is agreed during the Group or Panel meeting that the Serious Incident cannot be closed on STEIS due to outstanding information and/or assurance requirements, a member of the Patient Safety and Risk team will provide this information to the Provider in writing, within 48 hours of the Group or Panel meeting, detailing the requirements for closure (including expected timeframe for response).

7.58 For Type 1, Type 2 and Type 5 Serious Incidents, the outstanding information/assurance must be re-presented at a subsequent Serious Incident Review Group to facilitate closure. The Serious Incident Review Group will identify action plans within Provider RCAs that will be followed up at either three or six months following closure to gain assurance that learning has been embedded in practice.

7.59 For Type 3, Type 4 and 6 Serious Incidents, agreement will be reached during the Panel meeting as to whether, upon receipt of the outstanding information and/or assurance requirements:

- the panel must reconvene to facilitate closure;
- closure of the Serious Incident can be authorised by the Chair or other agreed representative.

This decision will be clearly documented in the panel notes and on Ulysses. The Panel will also request an update on the action plans in relation to closed Never Events and CCG led investigations at subsequent panel meetings.

7.60 The process for closing a Serious Incident can be found in Standard Operating Procedure 5-PS&R-05. This procedure also includes the process for following up on actions within the RCA action plans. In addition to the requirement for Duty of Candour process to be followed (as detailed in **Sections 7.15 – 7.23**), the NHS England Response to the Recommendations in the William Mead Root Cause Analysis May 2016 (Action 14.3b) also highlights the importance of having processes in place to ensure "*that actions are reviewed to provide assurance that all that should be done from the learning, has been done*".

Deleting Serious Incidents from STEIS

7.61 If a Serious Incident is declared but further investigation reveals that the definition of a Serious Incident is not fulfilled, the incident can be deleted.

7.62 Serious Incidents can only be deleted following agreement from the Serious Incident Review Group, Serious Incident Review Panel or the Panel Chair.

7.63 This process has been agreed, in writing, in conjunction with NHS England (Wessex).

7.64 The process for deleting a Serious Incident from STEIS can be found in Standard Operating Procedure 5-PS&R-06.

Commenting on non-Dorset Provider Serious Incident RCAs (including Never Event RCAs)

7.65 In a complex commissioning landscape where multiple commissioners may commission services from multiple providers spanning local and regional geographical boundaries, the model detailed throughout the Serious Incident Framework (i.e. where providers report incidents to the commissioner holding the contract who then assumes responsibility for overseeing the response to the serious incident) is not always practicable so a more flexible approach is required.

7.66 In such cases, the framework recommends that 'Commissioners must work collaboratively to agree how best to manage Serious Incidents for their services' and recommends the development of a RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model to agree the management of cross boundary Serious Incidents. This will ensure that it is clear who is responsible for learning oversight of the investigation, where the accountability ultimately resides and who should be consulted and/or informed as part of the process.

7.67 The formulation of RASCI agreements is undertaken on a case-by-case basis. Examples of RASCI agreements can be viewed in **Appendix D**. The first example details a simple investigation process whereby the Provider is a Dorset Provider and the patient resides in Dorset; the second details a more complex investigation whereby the Provider is a Dorset Provider but the patient resides outside of Dorset.

7.68 As per agreed Dorset processes, Serious Incidents Types 1, 2 and 5 are closed via the Serious Incident Review Group. When the Serious Incident involved one or more Dorset residents, but happened within a non-Dorset Provider, the mechanism for review remains the same (i.e.: is reviewed via the Review Group) however closure of the STEIS entry is the responsible of the NHS Clinical Commissioning Group who is the lead commissioner for the non-Dorset Provider (e.g. Yeovil Hospital, Salisbury Hospital, University Hospitals Southampton).

7.69 If the incident declared by a non-Dorset Provider is a Never Event involving one or more Dorset residents, the mechanism for review and feedback to the responsible CCG will be via the Serious Incident Review Panel.

7.70 In both circumstances referred to in **Sections 7.68** and **7.69** the group or panel may be held in person, or 'virtually' if the required meeting attendees are not able to meet in the timeframe given by the responsible CCG. Alternatively, a CCG representative may attend the panel held by the responsible CCG (e.g. NHS Wiltshire CCG or NHS West Hampshire CCG).

Reporting Serious Incidents within the CCG

7.71 A detailed theme/trend paper relating to Serious Incident occurrence, by Provider is provided in the Patient Safety and Risk paper for each Quality Group meeting.

7.72 The narrative and graphic paper is submitted quarterly by the Patient Safety and Risk Manager.

7.73 Information is also provided to the monthly information sharing group, the Quality and Safety Information Group (QSIG), a forum for the triangulation of information about serious and adverse incidents with other information and intelligence, as per the requirement of the Serious Incident Framework (NHS England, March 2015).

Framework application and interfaces with other sectors

7.74 There are occasions where the processes described in the Serious Incident Framework will coincide with other procedures. In such circumstances, co-operation and collaborative working between partner agencies is essential for minimising duplication, uncertainty and/or confusion relating to the investigation process. Ideally, only one investigation should be undertaken (by a team comprising representatives of relevant agencies) to meet the needs/requirements of all parties. However, in practice this can be difficult to achieve. Investigations may have different aims/ purposes and this may inhibit joint investigations. Where this is the case efforts must be made to ensure duplication of effort is minimised.

7.75 Wherever possible, Serious Incident investigations should continue alongside criminal proceedings but this should be considered in discussion with the police. In exceptional cases (i.e. following a formal request by police, Coroner or judge) the investigation may be put on hold via a 'stop the clock' mechanism.

7.76 The occasions when processes coincide with other procedures are:

- Deaths in custody where health provision is delivered by the NHS;
- Serious Case Reviews and Safeguarding Adult Reviews;
- Domestic Homicide Reviews (DHR);
- Homicide by patients in receipt of mental health care;
- Serious Incidents in National Screening Programmes

7.77 Supporting information on how to manage these circumstances can be found on pages 18-20 of the Serious Incident Framework. The role of the CCG in each of these circumstances reflects the requirements of the framework and local agreements:

Deaths in custody where health provision is delivered by the NHS

7.78 The CCG does not commission services for healthcare provision in prisons, however deaths in custody include individuals detained under the Mental Health Act (1983). An unexpected death (where natural causes are not suspected) and all deaths of detained patients must be reported immediately to the Coroner by the treating clinician and to the Care Quality Commission. It is recognised that, following an unexpected death, a Serious Incident may not be identified until

the issuing of the Coroner's report. Following an update to the Chief Coroner's Guidance in 2017, individuals subject to a Deprivation of Liberty Safeguard (DoLS) authorisation under the Mental Capacity Act (2005) are no longer considered to be detained and any unexpected deaths where there is concern about care or treatment before death should be investigated through established Serious Incident or Safeguarding processes.

Serious Case Reviews and Safeguarding Adult Reviews

7.79 The interface between the Serious Incident process and local Safeguarding procedures should be included in all local multi-agency safeguarding policies and protocols. The Head of Patient Safety and Risk provides the link to the Dorset Child Death Overview Panel (CDOP) to advise on Serious Incidents involving the death of children.

Domestic Homicide Reviews

7.80 The Pan Dorset Domestic Homicide Review Protocol has been developed based on Home Office Guidance and agreed by the Community Safety Partnerships. In this local agreement, DHR's are conducted through the Safeguarding Adults Review Sub-Group, overseen by both the Dorset and Bournemouth and Poole Safeguarding Adults Board and the role for the CCG is to support Primary Care (GPs) to provide an individual management report which analyses the involvement of the victim and perpetrator with GP services.

Homicide by patients in receipt of mental health care

7.81 In line with the Serious Incident Framework, NHS England commissions an independent investigation where there has been a homicide committed by a person in receipt of mental health services. These investigations ensure a wide scope looking at all aspects of health and care provision and will often involve health providers commissioned outside of Dorset. The CCG maintains oversight of the process and monitors recommendations made in relation to a provider that is directly commissioned.

Serious Incidents in National Screening Programmes

7.82 Any investigations involving the National Screening Programme will be led by a Provider, agreed during the initial scoping meeting and determined by a RASCI model (see **Appendix D**). The Patient Safety and Risk team will ensure that the NHS Screening and Immunisation Teams at NHS England/Public Health England are notified and involved through the investigation, closure and action monitoring.

8.0 TRAINING

8.1 There are no identified training needs in relation to this procedure as the process for the management of Serious Incidents is well established.

8.2 All CCG and Provider staff leading an investigation must receive appropriate training in the application of the Root Cause Analysis approach and tools for both concise and comprehensive investigations.

9.0 CONSULTATION

9.1 Those consulted during the development of this revised procedural document were:

- Quality Directorate Leadership team;
- Patient Safety and Risk team;
- Primary Care Quality Lead;
- Safeguarding Leads;
- Internal Audit;
- Governing Body, Nurse Member, NHS Dorset CCG;
- An independent GP member, NHS Dorset CCG

9.2 Regarding the need for an Equality Impact Assessment, following due consideration it has been determined that an Equality Impact Assessment is not required for this procedural document.

10.0 RECOMMENDATION AND APPROVAL PROCESS

10.1 As a 'Risk Management' procedural document, this procedure is to be approved by the Director's Performance Meeting.

10.2 This requirement reflects the process for recommendation and approval of procedural documents outlined in **Appendix F** of the 'Procedure of the development and management of procedural documents'.

11.0 COMMUNICATION/DISSEMINATION

11.1 Following approval, this procedure will be distributed via the CCG bulletin to all CCG staff and a copy will be uploaded to the CCG intranet.

11.2 A copy of the procedure will also be provided to Providers at the Patient Safety Event meeting in December 2017.

12.0 IMPLEMENTATION

12.1 As stated in **Section 8.1**, the procedure is established. There are, therefore, no additional implementation requirements.

13.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THE DOCUMENT

13.1 This procedure will be subject to an audit by Internal Audit on a cyclical basis. Dorset CCG has a three-year strategic plan, so this topic is likely to be subject to internal audit once every three years

13.2 Any areas of concern or non-compliance identified in the internal audit will result in the production of an action plan. This will be reviewed by Audit and Quality Committee. Actions will be recorded in the committee/group minutes.

13.3 Any areas of concern or non-compliance identified in the biennial audit will result in the production of an action plan. This will be reviewed by Audit and Quality Committee. Actions will be recorded in the committee/group minutes.

14.0 DOCUMENT REVIEW FREQUENCY AND VERSION CONTROL

14.1 This procedure is reviewed every two years to take account of any changes in national guidance. Necessary changes throughout the year will be issued as amendments to the procedure. Such amendments will be clearly identifiable to the section to which they refer and the date issued. These will be clearly communicated via the CCG newsletter.

TYPES OF SERIOUS INCIDENT **APPENDIX A**

No	Type Title	Description	Example	Terms of Reference	Duty of Candour	Closure mechanism
1	Provider Declared (Single Agency)	A Serious Incident which has taken place during care provided by one single Provider. The Serious Incident is investigated by the single Provider.	Patient A is admitted to Trust W following a fall at home. During their inpatient stay, Patient A falls and sustains a fracture to their neck of femur.	Written by Provider	Provider responsibility	Serious Incident Review Group
2	Provider Declared (Multi Agency)	A Serious Incident which has taken place during care provided by more than one Provider, but as a significant proportion of the care was undertaken by one provider, that Provider leads the investigation. The Serious Incident is investigated by the declaring Provider, supported by one or more other Providers.	Patient B is admitted to Trust X following a visit from their GP with acute confusion and hallucinations. During their inpatient stay, Patient B is successful in their attempt to jump from a first floor window and sustains serious ankle injuries. As the patient had been seen by their GP, who had requested the admission and had provided background information to the Trust on the medical history of Patient B, the GP was asked to contribute to the Serious Incident investigation. The local ambulance trust was also asked for a chronology of their involvement with Patient B as they conveyed the patient to Trust X.	Written by Provider (with input from contributing Providers)	Providers responsibility	Serious Incident Review Group
3	Provider Declared Never Event (Single Agency)	A Serious Incident which clearly meets the definition of a Never Event. The Serious Incident is investigated by the single Provider.	Patient C has two swabs inadvertently left in situ following an episode in theatre. This is discovered due to pain and failure of the wound to heal 10 days post-operatively.	Written by Provider	Provider responsibility	Serious Incident Review Board

No	Type Title	Description	Example(s)	Terms of Reference	Duty of Candour	Closure mechanism
4	CCG Declared (Internal CCG)	A Serious Incident which has taken place within the remit of the CCG's (e.g. information governance breach/property damage). The Serious Incident is investigated by the CCG.	The medical records, containing patient identifiable information, of five children who receive continuing healthcare funding are found in a shop in Bournemouth. The medical records are returned to the CCG by the shop's manager.	Written by CCG	CCG responsibility	Serious Incident Review Panel
5	CCG Declared (Single Agency)	A Serious Incident which has taken place at a Provider which does not have the ability to declare the incident directly on STEIS; the CCG therefore needs to declare the incident on behalf of the Provider.	Patient D lives in a nursing home and sustains a fracture to their neck of femur following a fall in the home, or/ The mother of Child E takes the child to a GP five times over an eleven-day period and a diagnosis of meningitis is missed until the child deteriorates and an ambulance is called to convey them to an Acute Provider.	Written by Provider	Provider responsibility	Serious Incident Review Panel
6	CCG Declared (Multi Agency)	A Serious Incident which has taken place during care provided by more than one Provider, but due to the complexity of the incident, and no one Provider being willing to declare and be the Lead, the Serious Incident is declared by the CCG. The Serious Incident is investigated by the CCG supported by two or more Providers.	Patient F, over a ten-day period, is seen by their GP, the district nursing team, paramedics (on two occasions, having dialled 999 and 111) and the Emergency Department team at Trust Y. On day 10 the patient died. Following a post mortem, the Coroner requests the case is declared as a Serious Incident as the patient died from peritonitis.	Written collaboratively by the Providers, and led by the Provider identified via the RASCI model (**Section 7.66**)	To be managed on a case by case basis, led by CCG	Serious Incident Review Panel

APPENDIX B

SERIOUS INCIDENT REVIEW GROUP/PANEL - TERMS OF REFERENCE

1.0 AUTHORITY AND PURPOSE

1.1 As per the requirements of the NHS England Serious Incident Framework (March 2015) commissioners are accountable for quality assuring the robustness of their Providers' Serious Incident investigations and the development and implementation of effective actions, by the Provider, to prevent recurrence of similar incidents.

1.2 The NHS Dorset Clinical Commissioning Group (CCG) Never Event and CCG Serious Incident Review Panel is responsible for ensuring a robust quality assurance process is in place for the closure of these incidents on behalf of the CCG Governing Body.

1.3 The Never Event and CCG Serious Incident Review Panel is responsible for reviewing and scrutinising all investigations and action plans received from Providers following Serious Incidents.

1.4 Provider led investigations of Serious Incidents which are not defined as Never Events and are not CCG led investigations will be closed by the CCG Serious Incident Review Group.

1.5 All Provider Never Events and CCG led investigations will be reviewed and closed by the Never Event and CCG Serious Incident Review Panel. This panel will have an enhanced level of senior scrutiny due to the requirements for Director level decision making with regard to financial penalties associated with Never Events. The panel membership will also ensure scrutiny of CCG led investigation by a lead GP and Governing Body member.

2.0 FUNCTIONS

2.1 The Serious Incident Review Group and Serious Incident Review Panel are responsible for:

- reviewing and scrutinising root cause analysis investigation reports of all Serious Incidents in any Provider where the CCG has the co-ordinating commissioning responsibility;
- pro-actively ensuring all Serious Incidents are fully investigated to identify the root causes using established assurance frameworks;
- monitoring the quality of investigations received;
- supporting timeliness of responses to investigations, prompting Providers if delays are occurring;
- seeking assurance that regular audit is in place to monitor actions from action plans;
- assuring that there are not systemic failures throughout the whole Provider organisation through the detailed review of reports and the clinical expertise of the Review Panel members;

- linking themes and trends to performance within Providers and any on-going quality concerns;
- authorising the closure of Serious Incidents and Never Events if satisfied that the investigation report and action plan meets the required standards

2.2 The Never Event and CCG Serious Incident Review Panel will have the additional responsibility with reference to Never Events and CCG led investigations, and will seeking assurance that agreed actions have been completed within the appropriate time scales.

3.0 Reporting, tracking and monitoring

3.1 The NHS England Serious Incident Framework states that incidents can be closed before all actions are complete but there must be mechanisms in place for monitoring on-going investigation.

3.2 All Never Events and CCG led investigations will be initially reviewed by the Serious Incident Review Group prior to submission to the Never Event and CCG Serious Incident Review Panel.

3.3 The Serious Incident Review Group will record outcomes on the panel outcome summary form (Appendix C) and share with the relevant provider. Any action plan which requires additional, focused follow up will be noted.

3.4 The monitoring of the Serious Incident action plans will take place as part of the provider contract quality review process by the contract leads for each organisation. The Serious Incident Review Group will highlight any emerging concerns from themes and trends to the contract leads for information. This ensures that the fundamental purpose of investigation (i.e. to ensure that lessons can be learnt to prevent similar incidents recurring) is realised.

3.5 Themes and trends from all serious incidents are also shared at the CCG Quality and Safety Information Group to ensure triangulation with emerging themes from other sources such as complaints, safeguarding, infection prevention and control and patient experience. This ensures key quality issues are shared across the system and lessons learned disseminated to relevant work streams.

3.6 The notes of the Never Event and Multi Agency Serious Incident Review minutes will detail meeting attendees and outcomes and will be produced following all panel meetings. This will be circulated to all meeting attendees and the relevant sections to the lead provider for each case.

4.0 MEMBERSHIP

4.1 Membership of the Serious Incident Review Group will comprise of:

- Head of Patient Safety and Risk, NHS Dorset CCG;
- Patient Safety and Risk Manager, NHS Dorset CCG;
- Patient Safety and Risk Facilitator, NHS Dorset CCG;
- Patient Safety and Risk co-ordinator, NHS Dorset CCG;
- As required only - NHS trust representative, (attends only the part of the meeting to present their cases) an independent GP.
- NHS West Hampshire CCG representation (if appropriate)

4.2 Membership of the Never Event and CCG SI Review Panel will comprise:

- Director of Nursing and Quality, or Deputy Director, NHS Dorset CCG (chair);
- Governing Body, Nurse Member, NHS Dorset CCG;
- An independent GP member, NHS Dorset CCG (no conflict of interest with any case presented);
- Head of Patient Safety and Risk, NHS Dorset CCG;
- Patient Safety and Risk Manager, NHS Dorset CCG;
- Head of Quality and Patient Safety, NHS West Hampshire CCG (for when Serious Incidents being reviewed involve West Hampshire residents);
- Patient Safety Manager, NHS England (Wessex);
- NHS trust representative, (attends only the part of the meeting to present their case)

4.3 In addition to the above members, other key staff will be invited to attend as required to meetings, for example, Safeguarding Leads, Medicines Management, Infection Control and Prevention team.

4.4 A note taker will also attend the Never Event Review Panel meeting, this will be either a member of the quality administration team or the Patient Safety and Risk Co-ordinator.

5.0 Quoracy

5.1 The Serious Incident Review Group will be quorate with attendance of at least two members, one of which will be a registered healthcare professional.

5.2 The Never Event Review Panel meeting will be quorate with attendance of at least four members of the panel to include the Director or Deputy Director of Nursing and Quality, NHS Dorset CCG, a GP clinical representative and two others.

5.3 Decisions on whether to close incidents will require the consensus of the group.

6.0 FREQUENCY OF MEETINGS

6.1 The Serious Incident Review Group will be scheduled to take place weekly, for one hour. This ensures all reports received have a quality assurance review within 20 calendar days as required in the NHS Serious Incident Framework, 2015. The papers for each meeting will be available no less than 24 hours ahead of each meeting to allow the attendees to prepare for the meeting discussion.

6.2 A Never Event and CCG SI Review Panel will be scheduled to take place bi-monthly throughout the year. A minimum of six weeks' notice is required to re-organise a panel if required and when there are no reports to review the meetings will be cancelled.

6.3 All panel meetings will be scheduled for two hours, but can be shortened if required.

6.4 The papers for each panel meeting will be circulated no less than five days ahead of each meeting to allow the attendees to prepare for the meeting discussion. For each Incident, the papers will include:

- Serious Incident Report;
- Serious Incident Action Plan

7.0 FREQUENCY OF REVIEW

7.1 Terms of Reference will be reviewed in 12 months or before if necessary to maintain the effectiveness of this group.

Version: 2
Date Agreed: 12.05.2017
Review Date: 12.05.2018

APPENDIX C

NHS
Dorset
Clinical Commissioning Group

Serious Incident Review Panel – Outcome Summary

Date of panel					
Attendees					
STEIS ref.		Incident date		Ulysses no.	
Category					
Originator					

	Y	N
Background and content. Is this clear and adequate?		
Investigation carried out by appropriate/suitable individuals?		
Appropriate scope and level of investigation		
Is it clear that all relevant information has been gathered to support full investigation?		
Evidence of 'Being Open' principles applied – patient and family involvement		
Evidence of Duty of Candour applied		
Chronology/timeline		
Care/service delivery problems identified		
Causal factors identified		
Root cause identified		
Good practice identified		
Recommendations are appropriate		
Action plan is robust and SMART		
Lessons learned are clearly identified		
Learning shared adequately and effectively		

Panel discussion topics

Outcome of first panel

Close		Delete		Close with questions		Close with actions for others		On-going	
Bring forward date for action plan follow up									

Questions/Actions

Response

Follow up panel

Date of panel											
Attendees											
Close		Delete		Close with questions		Close with actions for others		On-going			
Bring forward date for action plan follow up											

Questions/Actions

Action Plan follow up

Date of panel			
Attendees			
Follow up reported by		Date of action plan review	
Specific findings			
Any further action required			

EXAMPLE RASCIs

APPENDIX D

Example 1: Patient resides in Dorset	CCG	Acute Trust 1	Acute Trust 2	Mental Health & Community Trust	Ambulance Trust	GP Practice 1	Nursing/Care Home	Private Provider
Trust	Dorset CCG	PHFT	RBCH	-	SWASFT	-		
Duty of Candour		PHFT						
Declaring on STEIS		PHFT						

Example 2: Patient resides in Wiltshire	CCG 1	CCG 2	Acute Trust 1	Mental Health & Community Trust	Ambulance Trust	GP Practice 1	Nursing/Care Home	NHS England
Trust	Dorset CCG	NHS Wilshire	DCHFT	DHUFT		GP Practice A		NHS England
Duty of Candour			DCHFT					
Declaring on STEIS	Dorset CCG							

KEY:

R	**RESPONSIBLE**	The organisation assigned to do the work (the 'doer')
A	**ACCOUNTABLE**	The organisation making the final decision with ultimate ownership ('The buck stops here')
S	**SUPPORTING**	The organisation which will support the Responsible Provider ('Here to help')
C	**CONSULTED**	The organisation that must be consulted before a decision or outcome is taken ('In the loop')
I	**INFORMED**	The organisation which must be informed that a decision or action has been taken ('For your information')